Introduction

DEFINING DISASTER

Each day disasters occur, and each year millions of people are affected. Whether natural or human-made, the extreme and overwhelming forces of disaster can have far-reaching effects on individual, local community, and national stability. Though disasterous events may last from seconds to a few days, effects on communities and individuals can continue from months to years during the extended process of recovery, reconstruction and restoration. Long-term recovery varies significantly due to the complex interaction of psychological, social, cultural, political, and economic factors.

"A major disaster is defined as any natural catastrophe, or regardless of cause, any fire, flood, or explosion that causes damage of sufficient severity and magnitude to warrant assistance supplementing State, local, and disaster relief organization efforts to alleviate damage, loss, hardship, or suffering" *(FEMA, Pub 229 (4) November, 1995 p. 1).* Events associated with disaster are capable of causing traumatic stress when they cause or threaten death, serious injury, or the physical integrity of individuals.

In the event of massive destruction occuring in the United States, a Governor may request a Presidential declaration. This request must satisfy the provisions of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (PL93-288, as amended by PL-100-707). The Stafford Act provides the authority for the Federal Government to respond to disasters and emergencies in order to provide assistance to save lives and protect public health, safety, and property. High magnitude disasters can overwhelm state medical systems, posing public health threats related to food and

Photo by Donna Hastings

water supplies, housing and weather exposure, and injuries. Health care facilities may be severely structurally damaged or destroyed. Facilities with little or no structural damage may be rendered unusable or only partially usable because of a lack of utilities, losses of staff and equipment, limited resupply, and/or disruption of communication and transportation systems. Facilities remaining in operation face massive numbers of ill, injured, and/or stressed and disoriented victims.

Even in disasters with relatively few fatalities or injuries, disruptions of food supply, utilities, waste management, transportation, social, and educational services, together with property damage and survivor relocation often place intense demands on health services. Clearly, a timely and effective health care response is critical to the survivors' and the community's safety and recovery – and mental health care is an essential component in this response to disaster.

- In 1996-97, one hundred eighteen Presidential-declared disasters and eight national emergencies occurred in the United States, and the Federal Emergency Management Agency (FEMA) provided funding to 553,835 disaster victims.
  FEMA
- From 1984-1994, 285 Presidential-declared disasters occurred in the United States, one every two weeks on average.
  National Disaster Medical System Tenth Anniversary: A state by state guide (1994).
- Approximately 17 million people living in North America are exposed annually to trauma and disaster.
  Meichenbaum (1995).
- Approximately 25-30% of individuals exposed to unusually traumatic events such as disasters, combat, violence, and accidents develop chronic PTSD or other psychiatric disorders.
  Yehuda et al. (1994).

How This Guidebook Can Help

This guidebook is an introduction to the field of disaster mental health (DMH) for clinicians and administrators. Practical guidelines and background information are provided to assist you and/or your organization develop:

- ***Disaster Mental Health Response Strategies***

  Providing timely and phase-appropriate mental health services to disaster survivors, families, workers, and organizations.

We focus in detail on the pragmatics of delivering DMH services at disaster sites and over the long term in affected communities. Our goal is to help you provide a continuum of care for recovering survivors and their communities over the course of the days, months, and years following disaster.

- ***Disaster Mental Health Team Formation and Maintenance***

  Establishing a disaster mental health policy and team with operational protocols for timely and effective disaster mental health response and for team training and preparation.

Providing disaster mental health services is complex. We strongly advise developing a policy and a team *before* disaster strikes your community. Organizational policy must necessarily address the team's role during local or national emergencies/disasters, and outline how the team can become an integral element in the local and national response system.

We describe a series of practical steps necessary for creating, training, and sustaining a disaster mental health team. The roles of team leaders, mental health professional members, and non-professional ("peer") members are described.

- ***Strategies for Interfacing with the Federal Disaster Response System***

  Developing the capacity to interface with the federal disaster response system when mobilized for major disasters.

To respond to a high magnitude disaster, your team must be able to quickly integrate with the network of disaster response agencies and organizations. An overview of the federal disaster response system, its key agencies, and suggestions for how to join with this system is presented.

DISASTER MENTAL HEALTH SERVICES

In a major disaster, effective mental health response requires the delivery of both clinical and administrative services in ways that differ from services typically provided by mental health professionals. The primary objective of disaster relief efforts is to restore community equilibrium. Disaster mental health services, in particular, work toward restoring psychological and social functioning of individuals and the community, and limiting *the occurrence and severity of adverse impacts* of disaster-related mental health problems (e.g., post-traumatic stress reactions, depression, substance abuse).

Clinical Roles

The regular mission of mental health programs is significantly different from that of disaster mental health. Disaster mental health services are primarily directed toward "normal" people responding normally to an abnormal situation, and to identifying persons who are at risk for severe psychological or social impairment due to the shock of the disaster. Aspects of disaster intervention services are similar to the crisis work of mental health agencies and practitioners, and include the evaluation and treatment of persons whose pre-existing psychiatric disorders are exacerbated by the stress or trauma of disaster. However, most of the work of disaster mental health professionals occurs in "non-clinical settings" (e.g., shelters, disaster application centers, schools, community centers) and is delivered in the form of stress management education, problem solving, advocacy, and referral of at-risk or severely impaired individuals for more intensive clinical evaluation and care. In addition, defusing and debriefing, two commonly used disaster mental health interventions, may be unfamiliar to mental health clinicians.

Mental health providers thus face a unique challenge in the wake of disaster. In conventional clinical practice, patients generally arrive at a scheduled time having made an agreement (at least implicitly) to accept the clinician as a mental health expert. Clinics typically have private offices where clinicians and patients meet for a set time period. Following case management or therapeutic intervention, clinicians make progress notes, clients may do homework and return for follow-up work. After a few sessions, clinicians generally have an understanding of the client's presenting problem, coping style, and interpersonal dynamics. By contrast, disaster mental health involves services to people who often are not seeking mental health assistance, who may be ambivalent about receiving such help, or who may be outright resistant to any form of mental health service. Service settings may be chaotic, and lack privacy, quiet, or comfort – for example, a service center waiting line, a street curb, or a cot in a shelter. Moreover, administrative decisions about health services often change several times each day, requiring clinicians to frequently change their routines, locales, and the type of survivors

they serve. At most, 10-30 minutes can be spent with any individual, who is generally not seen more than once by the same clinician. "Instant" rapport and rapid assessment are necessary with many people who are experiencing extreme, but normal, stress reactions (e.g., exhaustion, irritability, grief). Although therapeutic skills and acumen provide a basis for disaster mental health assessment and intervention, mental health workers will not be doing "therapy" in the immediate wake of disaster. Rather, they address pragmatic concerns while using psychoeducational techniques to teach survivors about stress reactions and stress management methods.

Clinical roles change from setting to setting and they change over the course or "phases" of disaster. The primary clinical roles are discussed in detail in the sections "helping survivors," "helping the helpers," and "helping organizations." An outline of the primary clinical roles required during each phase is presented below.

Emergency Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disasters Mental Health Services	Protect Direct Connect Triage Acute Care	Triage / Assess Consult Defusing Debriefing Crisis intervention Referral when appropriate	Information dissemination	Consultation Needs Assessment Service development Support Employee Assistance Programs

Early Post-Impact Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster Mental Health Services	<u>Outreach Services</u> Assessment Referral Psychoeducational presentations Initial debriefings Follow-up debriefings Assistance with death notification Activities in large group settings & vigils	Assessment Consult Initial debriefings Referral when appropriate Follow-up debriefings Referral when appropriate	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management	Phone & on-site consultation to management Ad hoc counseling program design & implementation Support Employee Assistance Programs
SITES OF INTERVENTIONS	Shelters, meal sites, disaster application centers, Red Cross service centers, hospitals, schools, police stations, survivors' homes, morgues, (wherever survivors are)	Work sites Rest sites Home office	Newspapers, radio, TV, Internet, Community centers, shopping malls, schools, religious centers, business associations	Work sites Corporate offices

Restoration Phase: Clinical Roles

	SURVIVORS	HELPERS	COMMUNITY	ORGANIZATIONS
Types of Disaster Mental Health Services	Outreach Services PTSD Assessment Referral Psychoeducational presentations Debriefings Memorial & commemoration Clinical services Crisis intervention Consultation with schools; school programs PTSD and psychosocial assessment, Individual, couples, family & group counseling	Assessment & referral as appropriate Consultation Follow-up debriefings Referral when appropriate Commemoration planning	Psychoeducational articles, interviews, reports, brochures about stress reactions & stress management Needs Assessment survey Group education presentations Commemoration planning	Phone & on-site consultation Needs assessment surveys Educational presentations Consultations and trainings with Employee Assistance Programs

Administrative Roles

Following a disaster, administrators are faced with the challenge of having to quickly become familiar with disaster protocols (grant applications) and resources (mutual and other aid), while meeting rapidly emerging and changing disaster-precipitated needs. This work requires a good deal of "systems savvy" – ability to work within and effectively influence the institutional arrangements that define the overall disaster response and the community(ies) being served.

Disaster mental health response efforts are continuously subject to powerful real-world contingencies. All disasters become political events. Previously established networks and relationships, as well as political pressures, shape the disaster response. Consensus among agencies and organizations about matching resources with survivors is rare. The disaster setting is in constant flux as information and resources change rapidly. Hourly updates on community needs, political pressures, and the convergence of resources result in frequent reappraisal of how best to respond to the diverse groups of people affected.

Immediately following a disaster, administrators are beset by offers of mental health services from around the country (if not the world) inquiries from the media, and requests for needs assessments and logistical plans for how, where, and by whom mental health services will be delivered. Administrators also must begin preparation to shift services from crisis intervention to ongoing aid and assistance, because as early as one month after the disaster, the

major federal grants are reviewed, funded, and operationalized for ongoing disaster mental health services. All this begins within a period of 24-72 hours after the onset of disaster, leaving little time for information gathering and reflection.

Administrative crisis intervention in the wake of disaster involves several specific operations. An administrative team coordinating all on-site clinical provider teams will be convened quickly, and generally includes representation from key local and national mental health agencies and experts. Administrative representatives from various agencies (e.g., Emergency Medical Services, Office of Emergency Services, Critical Incident Stress Management, Department of Veterans Affairs, as well as representatives of professional mental health organizations) may be called upon to work within the rapidly forming mental health Incident Command established by county and state mental health organizations. Indigenous and non-indigenous mental health clinicians or administrators must have a portal of entry through at least one of these gatekeeper organizations in order to be legitimate "players" in the disaster response services. Administrators are best positioned if they have a prior working relationship with one or several of these teams, so as to have immediate access to experienced disaster mental health professionals .

Once "in the loop," administrative collaboration should occur with other mental health team leaders in order to sustain an effective overall intervention, including:

- communicating with other health and social services
- coordinating planning and decisions with the community's overall Incident Command System
- monitoring the delivery and effectiveness of mental health services in several sites
- converting ongoing assessments into timely reports, applications for funding, and guidelines for deployment of mental health programs and personnel

An outline of administrative roles and responsibilities in the immediate aftermath, early post-impact, and restoration phases of disaster follows:

EMERGENCY AND EARLY POST-IMPACT PHASE ADMINISTRATIVE TASKS

1. Coordinate response/liaison with other responding agencies	2. Coordinate immediate mental health response	3. Conduct needs assessment and/or gather information	4. Coordinate information to media for public dissemination	5. Coordinate services with other responding agencies to provide mental health services to emergency responders	6. Coordinate, allocate staff resources	7. Coordinate documentation of services
a. State Department b. American Red Cross c. Federal Emergency Management Agency d. County Office of Emergency Services e. School officials f. Community agencies	a. Mobilize team / staff to mass care sites b. If necessary, activate mutual aid system c. Establish disaster mental health crisis line (i.e., mechanism to respond to requests for services)	a. Impact on survivors: Number of fatalities, hospitalized, non-hospitalized, homes destroyed, homes with major damage, unemployed; schools destroyed; schools with major damage b. Impact on high-risk groups: Injured; high traumatic exposure; families and individuals relocated; frail elderly; economically disadvantaged; emergency responders / helpers		a. Defusing, debriefing, and crisis intervention services b. Education services c. Monitor DMH staff stress management	a. Existing local mental health staff b. Additional staff needed c. Specialized skills requirements (i.e., language, cultural, children, older adults, death notification, etc.)	

RESTORATION PHASE ADMINISTRATIVE TASKS

1. Coordinate response/liaison with other responding agencies	**2. Conduct needs assessment and/or gather information**	**3. Establish crisis counseling program**	**4. Coordinate outreach and clinical services**
a. State Department b. American Red Cross c. Federal Emergency Management Agency d. County Office of Emergency Services e. School officials f. Community agencies	a. Impact on survivors: Number of fatalities, hospitalized, non-hospitalized, homes destroyed, homes with major damage, unemployed; schools destroyed; schools with major damage b. Impact on high-risk groups: Injured; high traumatic exposure; families and individuals relocated; frail elderly; economically disadvantaged; emergency responders/helpers	a. Staffing b. Service contracts c. Program implementation d. Service facilities e. Equipment & supplies procurement f. Service announcements g.Obtaining specialized training for staff and inservices for staff h. Documentation of process and service provision i. Letters of acknowledgement j. Program evaluation k. After action reports l. Setting up archives	a. Staffing, scheduling, and assignments b. Monitoring staff stress c. Networking d. On-going assessment of special needs e. Develop library of psychoeducational materials for public dissemination f. Develop contacts with local media for information dissemination g. Commemorative event(s) planning

KEY CHARACTERISTICS & HELPING BEHAVIORS OF DISASTER MENTAL HEALTH WORKERS

Disaster mental health work requires a personal orientation toward adventuresomeness, sociability, and calmness. Equally important is having systems savvy, the ability to exhibit empathy, genuineness, positive regard for others, and the ability to provide therapeutic structure.

Generally speaking, adventuresomeness, sociability, calmness, systems savvy, and therapeutic acumen transcend theoretical orientation and are applicable across various disaster response settings. Moreover, they are essential to communicating with survivors and rescue workers whether informally or while providing practical help, defusing, debriefing, or information.

Adventuresomeness

Disaster work is a constant creative challenge with relatively few cardinal rules to provide *a priori* guidance. The inclination toward curiosity and learning from experience as well as the willingness to develop creative solutions to complex problems is necessary for disaster work. The person who relies upon routine with minimal uncertainty is likely to feel overwhelmed and adrift.

On the other hand, disasters require establishing regularity and certainty amidst intense turmoil, hence a major aspect of the adventure is creating structure in the face of chaos. The disaster worker who relies upon a series of "adrenaline rushes" by seeking out risky activities, extreme dangers, or opportunities to "push the envelope" is likely to be a charismatic success for a short time in disaster work ... but unable to facilitate, or accommodate, the gradual routinization necessary to provide stability for disaster survivors.

Sociability

Disaster mental health work demands long hours each day, as well as being on call throughout assignment. Survivors and workers alike are at their best and worst in a disaster – courageous, selfless, dedicated, resourceful, and compassionate ... yet also plagued by doubts, selfishness, resignation, confusion, and irritability. To work with people who may be experiencing extreme stress, and to maintain the stance of a sensitive and observant listener and helper, requires not just a professional commitment to others, but the capacity to enjoy and find the best in others.

However, sociability does not mean over-involvement or pseudo-friendliness. Disaster mental health professionals have the ethical and clinical responsibility to maintain clear and appropriate professional and personal boundaries with survivors and workers. Tact, discretion, and client-centeredness are an essential counter balance to being personable and friendly.

Calmness Disaster work is a form of non-stop crisis intervention challenging the equanimity of unexperienced and experienced clinicians alike. When nothing seems to be happening for hours at a time, powerful undercurrents of anxiety, despair, rage, and uncertainty threaten to break loose at any moment. Working and living conditions are often chaotic: noisy settings, long hours, substandard lodging, unstructured schedules, ambiguous roles and rules – these high-stress circumstances call for emotional poise.

Systems Savvy Disasters are political events. Turf and organizational politics are pervasive and volatile at disaster services sites, Incident Command center(s), and at national headquarters of response agencies. The disaster mental health professional represents a distinct interest – that of supporting and enhancing the psychosocial safety and functioning of helpers, survivors, and their community. By becoming familiar with the scope of disaster relief operations (i.e., community, state, and national political arenas), the mental health professional can better assume the role of an impartial mental health advocate.

Organizational and personal struggles may result in mental health professionals and programs becoming scapegoated as wasteful and an interference with the "real" work of restoring a community's physical and medical integrity after disaster. Alliances must be chosen carefully so that mental health is not marginalized.

Therapeutic Acumen To provide therapeutic assistance without "therapizing" disaster survivors or workers, the mental health professional's perspective must be grounded in empathy, genuineness, and respect. These "facilitative conditions" have been found to be essential across the spectrum of psychotherapy's theoretical models and help quickly promote a positive relationship between helper and survivor. These facilitative conditions are summarized on the following page.

Empathic behaviors:

- Express desire to comprehend survivor.
- Discuss what is important to survivor.
- Refer to survivor's feelings.
- Correctly interpret survivor's implicit feelings.

Genuine behaviors:

- Friendly and open.
- Spontaneous rather than rigid or overly formal.
- Actions congruent with intent.

Respectful behaviors:

- Be on time for appointments and meetings.
- Make statements that express respect for the survivor.
- Express non-verbal attentiveness and concern.
- Summarize survivor's messages accurately (e.g., appropriate eye contact, tone of voice).

Listening — Display a range of listening skills.

Listening behaviors

- Ask clarifying questions.
- Paraphrase survivors' statements accurately.
- Verbally reflect survivors' feelings accurately.
- Ask open-ended questions.
- Help clarify survivors' mixed (incongruent) messages.

Provide therapeutic structure — ability to conceptualize survivors' stress-related problems.

Behaviors providing therapeutic structure:

- Recognize overt and covert problems with stress.
- Recognize antecedent conditions that trigger stress responses.
- Understand how survivor's response to stress influences post-disaster behavior.
- Educate survivor about stress response syndromes & stress management strategies.
- Provide possible explanations for associated behaviors.
- Provide information that encourages alternative views and new behaviors.
- Assist, when appropriate, with pragmatic problems.
- Maintain the role of helper rather than friend or help-receiver.

Empathy:

Ability to help the survivor feel that he or she is understood.

Genuineness:

Ability to reduce the emotional distance or alienation between the survivor and oneself.

Positive regard for survivor:

Ability to convey respect for the survivor.

Listening

Ability to utilize array of listening skills